

SECTION 1915(c) WAIVER FORMAT

1. The State of Alabama requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

This is a request for a model waiver.

a. _____ Yes b. X No

If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

This waiver is requested for a period of (check one):

- a. X 3 years (initial waiver)
b. _____ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

- a. X Nursing facility (NF)
b. _____ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)
c. _____ Hospital
d. _____ NF (served in hospital)
e. _____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

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- a. ____ aged (age 65 and older)
- b. X disabled
- c. ____ aged and disabled
- d. ____ mentally retarded
- e. ____ developmentally disabled
- f. ____ mentally retarded and developmentally disabled
- g. ____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a. X Waiver services are limited to the following age groups (specify):

Age 21 and over

- b. ____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
- c. ____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.
- d. X Other criteria. (Specify):

Individuals receiving private duty nursing services through the EPSDT Program under the Alabama Medicaid State Plan who will no longer be eligible for this service upon turning age 21 and for whom private duty nursing services continues to be medically necessary based upon approved private duty nursing criteria outlined in Appendix B-2B.

e. ____ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

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6. This waiver program includes individuals who are eligible under medically needy groups.
- a. ____ Yes b. X No

7. A waiver of '1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.
- a. Yes b. No c. X N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.
- a. ____ Yes b. X No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.
- a. _____ Yes b. X No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:
- a. ____ Case management
 - b. ____ Homemaker
 - c. ____ Home health aide services
 - d. ____ Personal care services
 - e. ____ Respite care

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f.____ Adult day health

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- g.____ Habilitation
 - ____Residential habilitation
 - ____Day habilitation
 - ____Prevocational services
 - ____Supported employment services
 - ____Educational services
- h.____Environmental accessibility adaptations
- i.____Skilled nursing
- j.____ Transportation
- k.____Specialized medical equipment and supplies
- l.____Chore services
- m.____ Personal Emergency Response Systems
- n.____Companion services
- o. X Private duty nursing
- p.____Family training
- q.____Attendant care
- r.____ Adult Residential Care
 - ____Adult foster care
 - ____Assisted living
- s.____Extended State plan services (Check all that apply):
 - ____Physician services
 - ____Home health care services
 - ____Physical therapy services

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- _____ Occupational therapy services
- _____ Speech, hearing and language services
- _____ Prescribed drugs
- _____ Other (specify):

t. X Other services (specify):

**Personal Care/Attendant Service
Medical Supplies and Appliances
Assistive Technology**

u. The following services will be provided to individuals with chronic mental illness:

- _____ Day treatment/Partial hospitalization
- _____ Psychosocial rehabilitation
- _____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid Agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.
14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

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15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
- a. _____ When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).
 - b. _____ Meals furnished as part of a program of adult day health services.
 - c. _____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid Agency provides the following assurances to CMS:
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
 - 1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
 - 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
 - 3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
 - b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

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- c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
 - 1. Informed of any feasible alternatives under the waiver; and
 - 2. Given the choice of either institutional or home and community-based services.
- d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
- e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.
- f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.
- g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.
- h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.
- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may

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otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. X Yes b. No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. Yes b. X No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

18. An effective date of February 22, 2003 is requested.

19. The State contact person for this request is Felecia Barrow, who can be reached by telephone at (334) 242-5040.

20. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and Attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid Agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid

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plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid Agency.

Signature: _____

Print Name: Mike Lewis

Title: Acting Commissioner

Date: February 11, 2003

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APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

 X The waiver will be operated directly by the Medical Assistance Unit of the Medicaid Agency.

 The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

 The waiver will be operated by _____, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

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APPENDIX B - SERVICES AND STANDARDS**APPENDIX B-1: DEFINITION OF SERVICES**

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. _____ Case Management

_____ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1.____Yes 2.____No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1.____Yes 2.____No

_____ Other Service Definition (Specify):

b. _____ Homemaker:

_____ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

_____ Other Service Definition (Specify):

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c. _____ Home Health Aide services:

_____ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

_____ Other Service Definition (Specify):

d. _____ Personal care services:

_____ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

_____ Payment will not be made for personal care services furnished by a member of the individual's family.

_____ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

_____ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

_____ Standards for family members providing personal care services

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differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

_____ A registered nurse, licensed to practice nursing in the State.

_____ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

_____ Case managers

_____ Other (Specify):

3. Frequency or intensity of supervision (Check one):

_____ As indicated in the plan of care

_____ Other (Specify):

4. Relationship to State plan services (Check one):

_____ Personal care services are not provided under the approved State plan.

_____ Personal care services are included in the State plan, but with limitations. The waived service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

_____ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

_____ Other service definition (Specify):

e. _____ Respite care:

_____ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

_____ Other service definition (Specify):

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FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

_____ Individual's home or place of residence

_____ Foster home

_____ Medicaid certified Hospital

_____ Medicaid certified NF

_____ Medicaid certified ICF/MR

_____ Group home

_____ Licensed respite care facility

_____ Other community care residential facility approved by the State that its not a private residence (Specify type):

_____ Other service definition (Specify):

f. _____ Adult day health:

_____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

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Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1. ☐ Yes

2. ☐ No

☐ Other service definition (Specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. ☐ Habilitation:

☐ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

☐ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

☐ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless

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provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

____ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

____ Individuals will not be compensated for prevocational services.

____ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

____ Educational services, which consist of special education and related

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services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

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2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. ___ Yes 2. ___ No

_____ Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. _____ Environmental accessibility adaptations:

_____ Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

_____ Other service definition (Specify):

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i. _____ Skilled nursing:

_____ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

_____ Other service definition (Specify):

j. _____ Transportation:

_____ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

_____ Other service definition (Specify):

k. _____ Specialized Medical Equipment and Supplies:

_____ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

_____ Other service definition (Specify):

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l. _____ Chore services:

_____ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

_____ Other service definition (Specify):

m. _____ Personal Emergency Response Systems (PERS)

_____ PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

_____ Other service definition (Specify):

n. _____ Adult companion services:

_____ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

_____ Other service definition (Specify):

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o. X Private duty nursing:

_____ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

 X Other service definition (Specify):

See Scope of Service (Appendix B-2A)

p. _____ Family training:

_____ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

_____ Other service definition (Specify):

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q. _____ Attendant care services:

_____ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

_____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

_____ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

_____ Other supervisory arrangements (Specify):

_____ Other service definition (Specify):

r. _____ Adult Residential Care (Check all that apply):

_____ Adult foster care: Personal care services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care

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provider, cannot exceed___). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

____ Assisted living: Personal care services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

____ Home health care

____ Physical therapy

____ Occupational therapy

____ Speech therapy

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- _____ Medication administration
- _____ Intermittent skilled nursing services
- _____ Transportation specified in the plan of care
- _____ Periodic nursing evaluations
- _____ Other (Specify):

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

_____ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. X Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

- **Personal Care/Attendant Service—See Scope of Service (Appendix B-2A)**
- **Medical Supplies and Appliances:**
 Medical supplies and appliances includes devices, controls, or appliances specified in the Plan of Care, not presently covered under the State Plan, which enables the individual to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. All waiver medical supplies and appliances must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. Medical supplies and appliances does not include over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-tips, etc. Items reimbursed with waiver funds will be in addition to any medical supplies furnished under the State Plan and excludes those items which are not of direct medical or remedial benefit to the individual. Medical supplies and appliances are limited to \$1,800 per client per waiver year and documentation of items purchased will be maintained by the Alabama Medicaid Agency. An additional amount above that of \$1,800 may be requested by the client and approved by Medicaid if medically necessary.

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Categorical Listing of Medical Supplies & Appliances:

Mobility Support Devices, Bathing Support Devices, Toileting Support Devices, Feeding Support Devices and Augmentative Communication Devices

- **Assistive Technology:**

Assistive Technology includes devices, pieces of equipment or products that are modified, customized and are used to increase, maintain or improve functional capabilities of individuals with disabilities as specified in the Plan of Care. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an Assistive Technology device. Such services may include acquisition, selection, design, fitting, customizing, adaptation, application, etc. Items reimbursed with waiver funds excludes items which are not of direct medical benefit to the recipient. Receipt of this service must be determined medically necessary to prevent institutionalization as documented in the medical record and all items will meet applicable standards of manufacture, design and installation.

The amount for this service is \$20,000 per client. Any expenditure in excess of \$20,000 must be approved by the Alabama Medicaid Agency. The assistive technology item must be ordered by a physician, documented on the Plan of Care and must be prior authorized and approved by the Alabama Medicaid Agency's Prior Authorization Unit.

To obtain prior authorization numbers for this service, the case manager must submit a copy of the following documents to the Alabama Medicaid Agency (AMA):

1. Medicaid Prior Authorization Form (Form #342);
2. An agreement between the AMA and the company providing the service;
3. A price quotation list from the company supplying the equipment, providing a description of the item; and
4. A legible copy of the physician's prescription for the item.

Upon completion of service delivery, the client must sign and date acknowledging they were pleased with the service.

Providers of assistive technology shall be capable of supplying and training in the use of assistive technology devices.

t. _____ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in

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the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached.

Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

_____Physician services

_____Home health care services

_____Physical therapy services

_____Occupational therapy services

_____Speech, hearing and language services

_____Prescribed drugs

_____Other State plan services (Specify):

u._____Services for individuals with chronic mental illness, consisting of (Check one):

_____Day treatment or other partial hospitalization services (Check one):

_____Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
- b. occupational therapy, requiring the skills of a qualified occupational therapist,
- c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,
- d. drugs and biologicals furnished for therapeutic purposes,

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- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),
- g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other service definition (Specify):

_____ Psychosocial rehabilitation services (Check one):

_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level.

Specific psychosocial rehabilitation services include the following:

- a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- b. social skills training in appropriate use of community services;
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

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- a. vocational services,
- b. prevocational services,
- c. supported employment services, and
- d. room and board.

_____ Other service definition (Specify):

_____ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

_____ This service is furnished only on the premises of a clinic.

_____ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

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PENDIX B-2

PROVIDER QUALIFICATIONS

LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARDS
Personal Care/Attendant Service	Approved Home Health Vendor Personal Care/Attendant Worker	NA	NA	See minimum qualifications attached Scope of Services Individual: pg. 36-37 Agency: pg. 48 Section 40-1-1
Private Duty Nursing Service	Approved Private Duty Nursing Provider Registered Nurse Licensed Practical Nurse	X	NA	See minimum qualifications attached Scope of Services Individual: pg. 50-51 Agency: pg. 60 Section 40-1-1
Medical Supplies and Appliances	Durable Medical Equipment (DME) Provider	X	NA	Code of Alabama, 1975, 34-14C-3

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Assistive Technology	Durable Medical Equipment (DME) Provider	X	NA	Code of Alabama, 1975, 34-14C-3

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B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid Agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

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APPENDIX B-2A

**SCOPE OF SERVICE
FOR
PERSONAL CARE/ATTENDANT SERVICE (PC/AS)
TECHNOLOGY ASSISTED WAIVER FOR ADULTS**

A. Definition

Personal Care/Attendant Service (PC/AS) provides in-home and out-of-home (job site) assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair and vice versa, ambulation, maintaining continence, medication management and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

PC/AS is designed to increase an individual's independence and ability to perform daily activities and to support individuals with physical disabilities in need of these services as well as those seeking or maintaining competitive employment either in the home or an integrated work setting.

Personal Care/Attendant Service is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.

B. Objective

The objective of the Personal Care/Attendant Service (PC/AS) is to restore, maintain, and promote the health status of clients through home support, health observation, and support of and assistance with activities of daily living and independent activities of daily living in the home or in a work setting.

Personal Care/Attendant Service is to assist waiver clients in performing everyday activities when they have a physical, mental, or cognitive impairment that prevents them from carrying out those activities independently.

C. Description of Service to be Provided

1. This service will be provided to individuals with disabilities inside and outside of their home. It may enable them to enter or to maintain employment. The amount of time should be the number of hours sufficient to accommodate individuals with disabilities to work.

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2. The unit of service will be one (1) hour of direct PC/AS Service provided either in the client's residence or another setting outside of the home. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form or Service Provider Contract. The amount of time authorized does not include transportation time to and from the client's residence or place of employment or the Personal Care/Attendant Service Worker's break or mealtime.
3. The number of units and service provided to each client is dependent upon the individual client's needs as set forth in the client's Plan of Care established by the Case Manager, if case management is elected by the client, and subject to approval by the Alabama Medicaid Agency (AMA).

Medicaid will not reimburse for activities performed which are not within the scope of service.

4. If this service is being used for employment, the AMA will have a signed agreement with the employer stating that it is acceptable to have a PC/AS Worker on the job site.
5. PC/AS duties include:

- a. Support for activities of daily living, such as,

In-Home

- Bathing
- Dressing/Undressing
- Personal grooming
- Personal hygiene
- Meal preparation
- Consumption of food
- Assisting clients in and out of bed
- Assisting with ambulation
- Toileting and/or activities to maintain continence
- Bladder and Bowel care
- Medication management

- b. Home support that is essential to the health and welfare of the recipient, such as,

- cleaning
- laundry
- home safety

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Home safety includes a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the PC/AS Worker (PC/ASW) Supervisor as well as the Case Manager for follow-up.

Out-of-Home/Job Site

- Shopping
 - Transportation to and from work
 - Eating
 - Toileting
 - Taking medication
 - Banking/paying bills
 - Retrieving work materials that are out of reach
 - Entering or exiting doors
 - Distributing materials to different locations of the building when necessary.
- c. Reporting observed changes in the client's physical, mental or emotional condition.
- d. Reminding clients to take medication.
- e. Accompanying the client to necessary medical appointments, grocery shopping, and obtaining prescription medications. The PC/ASW is not allowed to transport clients, only to accompany them.

Note: Under no circumstances should any type of skilled medical or nursing service be performed by the PC/ASW.

D. Staffing

The DSP must provide all of the following staff positions through employment or subcontractual arrangements.

PC/ASW Supervisors and PC/AS Workers must be qualified, trained, and employed by a Medicare/Medicaid certified Home Health Agency or other health care agencies approved by the Commissioner of the Alabama Medicaid Agency.

1. Personal Care/Attendant Service Worker Supervisors must be a licensed nurse(s) who meet the following requirements:
 - a. Have references, which will be verified thoroughly and documented in the Direct Service Provider personnel file. (References may include criminal background checks, previous employers, and/or aide register.)

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- b. Be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is currently licensed by the Alabama State Board of Nursing to practice nursing.
 - c. Have at least two (2) years experience as an RN or LPN in public health, hospital, or long term care nursing.
 - d. Have the ability to evaluate the Personal Care/Attendant Service Worker (PC/AS Worker) in terms of his/her ability to carry out assigned duties and to relate to the client.
 - e. Have the ability to coordinate or provide orientation and in-service training to PC/AS Workers on either an individual basis or in a group setting.
 - f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of Personal Care/Attendant Service.
 - g. Submit to a program for the testing, prevention, and control of tuberculosis annually.
 - h. Possess a valid, picture identification.
2. PC/ASWs must meet the following qualifications:
- a. Have references which will be verified thoroughly and documented in the DSP's personnel file. (References may include criminal background checks, previous employers, and/or aide register.)
 - b. If providing in-home care, the service worker must be able to read and write.
 - c. If providing out-of-home care, the service worker must have at least a 10th grade education, preferably, high school graduate or GED recipient.
 - d. Possess a valid, picture identification.
 - e. Be able to follow the Plan of Care with minimal supervision.
 - f. Assist client appropriately with activities of daily living as related to personal care.
 - g. Complete a probationary period determined by the employer with continued employment contingent on completion of a Personal

Care/Attendant Service in-service training program. No Medicaid payment will be made for the probationary period.

- h. Must submit to a program for the testing, prevention, and control of tuberculosis annually.

3. Minimum Training Requirements for Personal Care/Attendant Service Workers:

The Personal Care/Attendant Service Worker training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing/or conducting the training. The Personal Care/Attendant Service training program must be approved by the Alabama Medicaid Agency. Proof of the training must be recorded in the personnel file.

Individual records will be maintained on each PC/ASW to document that each member of the staff has met the requirements below.

Minimum training requirements must include the following areas:

- a. Activities of daily living, such as,
 - Bathing (sponge, tub)
 - Personal grooming
 - Personal hygiene
 - Meal preparation
 - Proper transfer techniques (assisting clients in and out of bed)
 - Proper dressing/undressing techniques
 - Assistance with ambulation
 - Toileting
 - Feeding the client
- b. Home support, such as,
 - Cleaning
 - Laundry
 - Home safety
- i. Out-of-Home/Job Site activities, such as,
 - Shopping
 - Accompany a client to and from work

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- Proper techniques of medication management
 - Banking/paying bills
 - Proper techniques regarding retrieving work materials that are out of reach
 - Proper techniques regarding entering or exiting doors
- c. Recognizing and reporting observations of the client, such as,
- Physical condition
 - Mental condition
 - Emotional condition
 - Prompting the client of medication regimen
- d. Record keeping, such as,
- A service log signed by the client or family member/responsible person and PC/ASW to document what services were provided for the client in relation to the Plan of Care.
 - Submitting a written summary to the PC/ASW Supervisor of any problems with client, client's home or family. The Supervisor in return should notify the Case Manager.
- e. Communication skills
- f. Basic infection control/Universal Standards
- g. First aid emergency situations
- h. Fire and safety measures
- i. Client rights and responsibilities
- j. Other areas of training as appropriate or as mandated by Medicaid/Operating Agency
4. The DSP will be responsible for providing a minimum of twelve (12) hours of relevant in-service training per calendar year for each PC/AS Worker. In-service training is in addition to PC/AS Worker orientation training. For PC/AS Workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a PC/AS Worker.

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5. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.
6. Topics for specific in-service training may be mandated by the Medicaid Agency.
7. In-service training may entail demonstration of providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs must be approved for content and credit hours by the Medicaid Agency, prior to the planned training. The DSP shall submit proposed program(s) to the Alabama Medicaid Agency at least forty-five (45) days prior to the planned implementation.
8. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the twelve (12) hours required in-service for all PC/AS Workers each calendar year.
9. The DSP Agency shall maintain records on each employee, which will include the following:
 - a. Application for employment;
 - b. Job description;
 - c. Record of health (annual tuberculin tests);
 - d. Record of pre-employment and in-service training;
 - (1) For PC/AS Supervisor validation of required CEUs for licensure will be accepted.
 - e. Orientation;
 - f. Evaluations;
 - g. Supervisory visits;
 - h. Copy of photo identification;
 - i. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;
 - j. Reference contacts;
 - k. Other forms as required by state and federal law, including

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agreements regarding confidentiality.

E. Procedures for Service

1. The Case Manager, if elected by the client, will submit a Service Authorization Form and Plan of Care to the DSP Agency authorizing Personal Care/Attendant Service and designating the units, frequency, beginning and ending dates of service, and types of duties in accordance with the individual client's needs. If case management is not elected by the client, all service coordination efforts will be handled through the Alabama Medicaid Agency.
2. The DSP Agency will initiate PC/AS Service within three (3) working days of receiving the Service Authorization Form in accordance with the following:
 - a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form.
 - b. The DSP Agency will adhere to the services and schedule as recommended by the Case Manager and authorized by the AMA on the Service Authorization Form. No payment will be made for services unless authorized and listed on the Plan of Care.
3. Provision of Service Authorized:
 - a. The Personal Care/Attendant Service Worker will not be allowed to provide transportation when he/she is accompanying a client.
 - b. Personal Care/Attendant Service Workers will maintain a separate service log for each client to document their delivery of services.
 - (1) The Personal Care/Attendant Service Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.
 - (2) The service log must be signed upon each visit by the client, or family member/responsible party and the PC/AS Worker. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Personal Care/Attendant Service Worker must document the reason the log was not signed by the client or family member/responsible party.
 - (3) The service log will be reviewed and signed by the PC/AS Supervisor at least once every two (2) weeks. Service logs will be retained in the client's file.

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- (4) Client visits may be recorded electronically via telephony. Electronic documentation will originate from the client's residence or other location of service as indicated by the client. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

- c. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care and are employed by an approved provider of service. However, providers of service cannot be a parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to assure that payment is made to the relatives or friends as providers only in return for Personal Care/Attendant Services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the Case Manager's file showing the lack of other qualified providers in remote areas. The Case Manager, if elected by the client, will conduct an initial assessment of qualified providers in the area of which the client will be informed. The Case Manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The Case Manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for clients living in a remote area.

4. Monitoring of Service:

PC/AS Service must be provided under the supervision of the registered nurse or licensed practical nurse who meets the requirements of D.1. and will:

- a. Make the initial visit to the client's residence prior to the start of PC/AS Service for the purpose of reviewing the Plan of Care and providing the client written information regarding advance directives.

The initial visit should be held at the client's place of residence and should include the Case Manager, if elected by the waiver client, the PC/AS Supervisor, the client, and the caregiver, if feasible. It is advisable to also include the PC/AS Worker in the initial visit.

- b. Be immediately accessible by phone during the time PC/AS is being provided. Any deviation from this requirement must be prior approved in writing by the Alabama Medicaid Agency. If this position becomes vacant the Alabama Medicaid Agency must be notified within 24 hours when the position becomes vacant.

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- c. Provide and document supervision of, training for, and evaluation of PC/ASWs according to the requirements in the approved waiver document.
- d. Provide on-site (client's residence or other location of service) supervision of the PC/ASW at a minimum of every sixty (60) days for each client. Supervisory visits must be documented in the individual client record and a copy placed in the worker's personnel file. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the PC/ASW. In the event the on-site supervisory visit cannot be completed in a timely manner due to the client's being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Personal Care/Attendant Service. Documentation regarding this action should be in the DSP client record.
- e. The DSP must complete the sixty (60) day supervisory review which includes, at a minimum, assurance that the services are being delivered consistent with the Plan of Care and the Service Authorization Form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. The summary must be submitted to the Case Manager within ten (10) calendar days after the sixty (60) day supervisory review. In the event the client is not available during the time the visit would have normally been made, the review must be completed within five (5) working days of the resumption of PC/AS Service.
- f. Assist PC/ASWs as necessary as they provide individual Personal Care/Attendant Service as outlined in the Plan of Care. Any supervision/assistance given must be documented in the individual client's record.
- g. Direct supervisory visits must be documented in the PC/AS Worker's personnel record.
 - (1) Direct supervision may be carried out in conjunction with an on-site supervisory visit.

The PC/ASW Supervisor will provide and document the supervision, training, and evaluation of PC/AS Workers according to the requirements in the approved waiver document.

5. Missed Visits and Attempted Visits

a. Missed Visits

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- (1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.
- (2) The DSP shall have a written policy assuring that when a Personal Care/Attendant Service Worker is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary/or reduced by the DSP.

Clients who are designated by the Case Manager as being at-risk should be given first priority when Personal Care/Attendant Service visits must be temporarily prioritized and/or reduced by the DSP.

- (a) If the PC/ASW Supervisor sends a substitute, the substitute will complete the service log and obtain signature from the client or family member/responsible party after finishing duties.
 - (b) If the PC/ASW Supervisor does not send a substitute, the Supervisor will contact the client and family member/responsible party and inform them of the unavailability of the Personal Care/Attendant Service Worker. The Personal Care/Attendant Service Worker Supervisor will ensure that the client's health and safety are not at risk.
- (3) The DSP will document missed visits in the client's files.
- (4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the Case Manager or the Alabama Medicaid Agency must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the **"Weekly Missed/Attempted Visit Report"** form to the Case Manager on Monday of each week. Any exception to the use of this form must be approved by the Alabama Medicaid Agency.
- (5) The DSP may **not** bill for missed visits.

b. Attempted Visits

- (1) An attempted visit occurs when the PC/ASW arrives at the home and is unable to provide services because the client is not at home or refuses services.

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- (2) If an attempted visit occurs:
 - (a) The DSP may **not** bill for the attempted visits.
 - (b) The Supervisor will contact the client to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.
 - (c) The DSP will notify the Case Manager or the AMA promptly whenever an attempted visit occurs.
 - (d) The DSP Agency shall furnish to the Alabama Medicaid Agency the daily hours of operation.

6. Changes in Services

- a. The DSP will notify the Case Manager or the AMA within one (1) working day of the following changes:
 - (1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs;
 - (2) Client does not appear to need Personal Care/Attendant Service;
 - (3) Client dies or moves out of the service area;
 - (4) Client indicates Personal Care/Attendant Service is not wanted; and,
 - (5) Client loses Medicaid financial eligibility;
 - (6) When services can no longer be provided.
- b. The Case Manager or the AMA will notify the DSP immediately if a client becomes medically or financially ineligible for waiver services.
- c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager or the AMA to discuss having these duties added.
 - (1) The Case Manager or the AMA will review the DSP's request to modify services and respond within one (1) working day of the request.

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- (2) The Case Manager or the AMA will approve any modification of duties to be performed by the PC/ASW and re-issue the Service Authorization Form accordingly.
- (3) Documentation of any change in a Plan of Care will be maintained in the client's file.
 - (a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager or the AMA.
 - (b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager or the AMA.
 - (c) If an individual declines PC/AS Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager or the AMA.

7. Documentation and Record-Keeping

- a. The DSP shall maintain a record keeping system for each client that documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available to Medicaid, or other agencies contractually required to review information upon request.

The DSP shall maintain a file on each client, which shall include the following:

- (1) A current HCBS application;
- (2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Personal Care visits for the client;
- (3) Documentation of client specific assistance and/or training rendered by the Supervisor to a Personal Care/Attendant Service Worker;
- (4) All service logs;
 - (a) The service log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.

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- (5) Records of all missed or attempted visits;
 - (6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken; and,
 - (7) Evaluations from all 60 day on-site supervisory visits to the client;
 - (8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;
 - (9) Initial visit for in-home services;
 - (10) Any other notification to Case Manager;
 - (11) Permission statements to release confidential information, as applicable.
- b. The DSP will retain a client's file for at least five (5) years after services are terminated.
 - c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

- 1. The AMA has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.
- 2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of PC/AS Service provided and/or the DSP Agency and will provide information about how to register a complaint with the Case Manager and the Alabama Medicaid Agency.
 - a. Complaints which are made against PC/ASW will be investigated by the DSP Agency and documented in the client's file.
 - b. All complaints which are to be investigated will be referred to the PC/ASW Supervisor who will take appropriate action. The proposed action to be taken will be forwarded to the Alabama Medicaid Agency for review.
 - c. The PC/ASW Supervisor will take any action necessary and document the action taken in the client's and/or the employee's files, whichever is most

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appropriate based on the nature of the complaint. This information will be forwarded to the Alabama Medicaid Agency for review.

- d. The PC/ASW Supervisor will contact the Case Manager or the Alabama Medicaid Agency by letter or telephone about any complaint and any corrective action taken.
3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the Alabama Medicaid Agency within three (3) working days of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.
2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the Alabama Medicaid Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Alabama Medicaid Agency.
3. The DSP Agency must have written bylaws or equivalent, which are defined as "a set of rules adopted by the DSP Agency for governing the agency's operations." Such bylaws or equivalent shall be readily available to staff of the DSP Agency and shall be provided to the Alabama Medicaid Agency upon request.
4. Administrative and supervisory functions shall **not** be delegated to another agency or organization.
5. A list of the members of the DSP's governing body shall be made available to the Alabama Medicaid Agency upon request.

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6. An annual operating budget, including all actual and anticipated revenue and expenses must be submitted to the Alabama Medicaid Agency prior to the signing of the initial contract. The budget must comply with Governmental Accepted Accounting Principles (GAAP) guidelines. The DSP Agency must maintain an annual operating budget, which shall be made available to the Alabama Medicaid Agency upon request.
7. The DSP Agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the Alabama Medicaid Agency.
8. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid and/or its agents.
9. The DSP Agency shall maintain an office, which is open during normal business hours and staffed with qualified personnel.
10. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Alabama Medicaid Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.
11. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

H. Provider Experience

Providers of Personal Care/Attendant Service must meet all provider qualifications prior to rendering the Personal Care/Attendant Service.

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APPENDIX B-2A

**SCOPE OF SERVICES
FOR
PRIVATE DUTY NURSING (PDN) SERVICE
TECHNOLOGY ASSISTED WAIVER FOR ADULTS**

A. Definition

The Private Duty Nursing Service is a service which provides skilled medical observation and nursing services performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act and the Alabama State Board of Nursing. Private Duty Nursing under the waiver will not duplicate Skilled Nursing under the mandatory home health benefit in the State Plan. If a waiver client meets the criteria to receive the home health benefits, home health should be utilized first and exhausted before Private Duty Nursing under the waiver is utilized.

Private Duty Nursing Services are not an entitlement. They are based on the needs of the individual client as reflected in the plan of care.

B. Objective

The objective of the Private Duty Nursing Service is to provide skilled medical monitoring, direct care, and intervention for individuals 21 and over to maintain him/her through home support. This service is necessary to avoid institutionalization.

Medicaid will not reimburse for activities performed which are not within the scope of services defined.

C. Description of Service to be Provided

1. The unit of service is one (1) hour of direct Private Duty Nursing care provided in the client's home or other location of service. The number of units authorized per visit must be stipulated on the Plan of Care (POC) and Service Authorization Form. The amount of time authorized does not include transportation time to and from the client's residence or other location of service or the Private Duty Nurse's break or mealtime.
2. The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's POC established by the Case Manager if case management is elected by the client, and is subject to approval by the Alabama Medicaid Agency (AMA). **Private Duty Nursing Services shall be reimbursable for up to twelve (12) hours per day per client except as otherwise provided on page 63, item 5.**

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3. Private Duty Nursing Service duties include:
 - (a) Administering medications and treatments prescribed by a licensed or otherwise legally authorized physician or dentist.
 - (b) Additional acts requiring appropriate education and training designed to maintain access to a level of health care for the consumer may be performed under emergency or other conditions, which are recognized by the nursing and medical professions as proper to be performed by a registered nurse.
4. The Private Duty Nursing Service provider will provide skilled services as ordered by the physician, will evaluate effectiveness of these services, and report changes in conditions as warranted.

D. Staffing

The Direct Service Provider (DSP) will be an enrolled Private Duty Nursing Agency and must provide all of the following through employment or subcontractual agreements.

1. A licensed practical nurse (LPN) or registered nurse (RN) who meets the following requirements:
 - a. Is currently licensed by the Alabama State Board of Nursing to practice nursing.
 - b. Has at least two (2) years experience in public health, hospital, home health or long term care nursing.
 - c. Must submit to a program for the testing, prevention, and control of tuberculosis, annually.
 - d. Private Duty Nursing Services provided by an LPN requires supervision by a licensed RN.
2. Minimum training requirements for Licensed Practical Nurses and Registered Nurses:
 - a. The DSP assures the Alabama Medicaid Agency that the nurse has adequate experience and expertise to perform the skilled services ordered by the physician.
 - b. The DSP will provide for a minimum of six (6) hours of relevant in-service training per year based upon the date of employment for each nurse.

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3. Private Duty Nursing Service Supervisors' Qualifications – See Section D.1 a.-c. In addition, Private Duty Nursing Supervisors must:
 - a. Have the ability to evaluate the private duty nurse in terms of his/her ability to carry out assigned duties and relate to the client;
 - b. Have the ability to coordinate or provide orientation and in-service training to the private duty nurse on either an individual basis or in a group setting; and
 - c. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers' dissatisfaction, complaints or grievances regarding the provision of private duty nursing services.

E. Procedures for Service

1. The DSP will obtain the initial physician's order for private duty nursing. A copy will be sent to the Case Manager, if the Case Management service has been elected by the client, to be placed in the client's file. Written orders are preferable, however, in some situations the nurse may accept a verbal order provided the nurse obtains the physician's signature within two (2) working days from receipt of the verbal order.
2. The Case Manager will authorize and submit a Service Authorization Form to the DSP Agency authorizing private duty nursing services and designating the units, frequency, duration, and types of duties in accordance with the individual client's needs. This documentation will be maintained in the client's file.
3. The DSP Agency will initiate private duty nursing within three (3) working days of receipt of the Service Authorization Form in accordance with the following:
 - a. Services must not be provided prior to the authorized start date as stated on the Service Authorization Form.
 - b. The DSP Agency will adhere to the services and schedules authorized by the Case Manager on the Service Authorization Form. No payment will be made for services unless authorized on the Service Authorization Form and listed on the POC.
4. The DSP of private duty nursing services must send the physician's treatment plan to the Case Manager, which includes treatment goals, after completion of the first private duty nursing visit. The information provided here will be used to complete the POC for the waiver client.

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5. The DSP Agency may recommend to the Case Manager any changes in the hours, times, or specified duties requested. The Case Manager will review a client's Plan of Care within one (1) working day of the DSP's request to modify the Plan of Care. A change in the Service Authorization Form must be submitted to the DSP Agency by the Case Manager. All requests which involve a change in the number of hours must be forwarded to the Alabama Medicaid Agency for approval. If necessary, the DSP will be responsible for procuring the skilled nursing orders from the physician.
6. A record keeping system will be maintained which establishes an eligible client profile in support of units of private duty nursing. A service log will reflect the services provided by the RN or LPN and the time expended for this service.
7. An individual client record must be maintained by the Case Manager and the DSP. The DSP will maintain the individual client record if the client does not elect the Case Management service. The DSP will retain a client's file for at least five (5) years after services are terminated.
8. Each client under the waiver must provide the name of a designated person(s) and telephone number(s) to the Case Manager or the DSP Agency to ensure the maintenance of seven (7) day, twenty-four (24) hour a day client accessibility. This information will be maintained in the client's record.
9. The DSP of private duty nursing services must develop and maintain a Policy and Procedure Manual approved by the Alabama Medicaid Agency, which describes how it will perform its activities in accordance with the terms of the contract.
10. The Case Manager will notify the DSP immediately if a client becomes medically ineligible for waiver services. The Case Manager will verify Medicaid eligibility on a monthly basis.
11. Provision of Service authorized:
 - a. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care and are employed by an approved provider of service. However, providers of service cannot be a parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to assure that payment is made to the relatives or friends as providers only in return for private duty nursing services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the Case Manager's file showing the lack of other qualified providers in remote areas. The Case Manager, if elected by the client, will conduct an initial assessment of qualified providers in the area of which the client will be informed. The Case Manager must document

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in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The Case Manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for clients living in a remote area.

- b. The private duty nurse is not allowed to provide transportation when he/she is accompanying a client. The RN/LPN may accompany the client, if necessary, to medical appointments. Or, in emergency situations, transport a client to the hospital emergency department via ambulance.
- c. The private duty nurse will maintain a service log, as well as nurses' notes to document their delivery of services.
 - (1) The private duty nurse shall complete a service log that will reflect the types of services provided, the number of hours of service and the date and time of the service. The nurses' notes should reflect the provision of service and the observed condition of the client.
 - (2) The service log must be signed upon each visit, by the client or family member/responsible party. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the private duty nurse must document the reason the log was not signed by the client or family member/responsible party.
 - (3) Client visits may be recorded electronically via telephony. Electronic documentation will originate from the client's residence or other location of service as indicated by the client. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

12. Monitoring of Service

The Private Duty Nursing Service Supervisor will visit the home of clients to monitor services provided by a licensed LPN.

- a. The Private Duty Nursing Service Supervisor will provide on-site supervision at a minimum of every 60 days for each client. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the LPN.

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- b. Each supervisory visit conducted will be documented in the client's file. The Private Duty Nursing Service Supervisor's report of the on-site visits will include, at a minimum:
 - 1) Documentation that services are being delivered consistent with the Plan of Care;
 - 2) Documentation that the client's needs are being met;
 - 3) Reference to any complaints which the client or family member/responsible party has lodged and action taken; and
 - 4) A brief statement regarding any changes in the client's private duty nursing service needs.
- c. The Supervisor will provide private duty nursing assistance to the LPN as necessary based on the outlined POC. Any supervision/assistance given must be documented in the individual client record.
- d. Private Duty Nursing Service Supervisors will be immediately accessible by phone. Any deviation from this requirement must be prior approved in writing by the Alabama Medicaid Agency. If this position becomes vacant, the Alabama Medicaid Agency must be notified within 24 hours when the position becomes vacant.

13. Missed Visits, and Attempted Visits

- a. Missed Visits
 - 1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.
 - 2) The DSP shall have a written policy assuring that when a private duty nurse is unavailable the Supervisor will assess the need for services and make arrangements for a substitute RN or LPN to provide services as necessary.
 - (a) If the supervisor sends a substitute RN or LPN, the substitute will complete the service log and obtain signature or telephone authorization from the client or family member/responsible party after completion of duties.
 - (b) If the Supervisor is not able to send a substitute RN or LPN, the Supervisor will contact the client or family member/responsible party and inform them of the

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unavailability of the Private Duty Nurse. The Supervisor must ensure that the client's health and safety is not at risk.

- 3) The DSP will document missed visits in the client's files.
- 4) Whenever the DSP determines that services cannot be provided as authorized, the Case Manager must be notified by telephone immediately. All missed visits must be reported in writing on the Medicaid's "WEEKLY MISSED VISIT REPORT" form to the Case Manager on Monday of each week.
- 5) The DSP may not bill for missed visits.

b. Attempted Visits

- 1) An attempted visit occurs when the private duty nurse arrives at the home and is unable to provide services because the client is not at home or refuses services.
- 2) If an attempted visit occurs:
 - a) The DSP may not bill for the attempted visits.
 - b) The private duty nurse will contact the client to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.
 - c) The DSP will notify the Case Manager or the AMA promptly whenever an attempted visit occurs.
 - d) The DSP Agency shall furnish to the AMA the daily hours of operation.

14. Changes in Services

- a. The nurse will notify the Case Manager or the AMA within one (1) working day of the following client changes:
 - 1) Client's condition has changed and the service plan no longer meets the client's needs or the client no longer needs private duty nursing services.
 - 2) Client dies or moves out of the service area.
 - 3) Client no longer wishes to receive the private duty nursing service.

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- 4) Client loses Medicaid financial eligibility.
- b. The Case Manager or the AMA will notify the DSP immediately if a client becomes medically ineligible for waiver services.
 - c. If the DSP identifies additional duties that would be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager or the AMA to discuss having these duties added.
 - 1) The Case Manager or the AMA will review the DSP's request to modify services and respond within one (1) working day of the request.
 - 2) The Case Manager or the AMA will approve any modification of duties to be performed by the private duty nurse and re-issue the Service Authorization Form accordingly.
 - 3) Documentation of any changes in a Plan of Care will be maintained in the client's file.
 - a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager or the AMA.
 - b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager or the AMA.
 - c) If an individual declines the private duty nursing service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager or the AMA.

15. Documentation and Record-Keeping

- a. The DSP shall maintain a record keeping system, which documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available upon request to Medicaid, the operating agencies, or other agencies contractually required to review information upon request.

The DSP shall maintain a file on each client, which will include the following:

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- 1) The most recent assessment performed, including the plan of care;
 - 2) A current HCBS application;
 - 3) Both current and historical Service Authorization Forms specifying units, services, and schedule of Private Duty Nursing visits for the client;
 - 4) All service logs reflecting the services provided by the LPN or RN;
 - 5) All nurses' notes reflecting the provision of services and the observed condition of the client;
 - 6) All service logs and nurses' notes:
 - (a) Must be reviewed and initialed by the Private Duty Nurse Supervisor at least once every two (2) weeks.
 - 7) Records of all missed or attempted visits;
 - 8) Records of all complaints lodged by clients or family members/responsible parties and any actions taken; and
 - 9) Evaluations from all 60 day on-site supervisory visits to the client.
 - 10) The Service Authorization Form notifying the DSP Agency of termination, if applicable.
 - 11) Initial visit for in-home services;
 - 12) Any other notification to Case Manager;
 - 13) Permission statements to release confidential information, as applicable.
- b. The DSP will retain a client's file for at least five (5) years after services are terminated.
- c. The DSP Agency shall maintain records on each employee, which shall include the following:
- 1) Each employee's application for employment;
 - 2) Job description;
 - 3) Record of health (annual tuberculin tests);
 - 4) Record of pre-employment and in-service training;

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- 5) Orientation;
- 6) Evaluations;
- 7) Work attendance;
- 8) Supervisory visits;
- 9) Copy of photo identification;
- 10) Complaint file/resolutions; and
- 11) Reference contacts.

- d. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

E. Rights, Responsibilities, and Service Complaints

- 1. The AMA has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.
- 2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of private duty nursing services provided and/or the DSP Agency and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.
 - a. Complaints that are made against nurses will be investigated by the DSP and documented in the client's file.
 - b. All complaints to be investigated regarding services provided by the RN/LPN of the DSP Agency will be referred to the Private Duty Nursing Service Supervisor who will take appropriate action. The proposed action to be taken will be forwarded to the Alabama Medicaid Agency for review.
 - c. The Private Duty Nursing Service Supervisor and DSP will take actions necessary and document the action taken in the client's and employee's files. This information will be forwarded to the Alabama Medicaid Agency for review.
 - d. The DSP or Private Duty Nursing Service Supervisor will contact the Case Manager or the Alabama Medicaid Agency by letter or telephone about any complaint and any corrective action taken.

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3. The DSP must maintain documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP shall designate an individual to serve as the administrator who shall employ qualified personnel and ensure adequate staff education, in-service training, and perform employee evaluations. This does not have to be a full-time position; however, the designated administrator will have the authority and responsibility for the direction of private duty nursing services for the DSP Agency. The DSP Agency shall notify the operating agencies within three (3) working days in the event of a change in the administrator, address, telephone number, or of an extended absence of the agency administrator.
2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility to staff providing "hands on" client care and shall be set forth in writing. This information will be readily accessible to all staff. A copy of this shall be forwarded to the Alabama Medicaid Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Alabama Medicaid Agency.
3. The DSP Agency must have written bylaws or equivalent, which are defined as "a set of rules adopted by the DSP Agency for governing the agency's operations." Such bylaws or equivalent shall be readily available to staff of the DSP Agency and shall be provided to the Alabama Medicaid Agency upon request.
4. Administrative and supervisory functions will not be delegated to another organization.
5. A list of the members of the DSP's governing body shall be available to the Alabama Medicaid Agency upon request.
6. The DSP will maintain a policy and procedures manual to describe how activities will be performed in accordance with the terms of this contract and include the organization's emergency plan. All policies and procedures shall be kept in the organization's manual, which shall be available during office hours for the guidance of the governing body, personnel, and to the operating agencies upon request. The manual is subject to the approval of the Alabama Medicaid Agency.
7. The DSP shall acquire and maintain liability insurance during the life of this contract to protect all paid and volunteer staff, including board members, from

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liability incurred while acting on behalf of the DSP. Upon request, the DSP shall furnish a copy of the insurance policy to the Alabama Medicaid Agency.

8. The DSP shall conform to applicable federal, state and local health and safety rules and regulations, and have an on-going program to prevent the spread of infectious diseases among its employees.
9. The DSP shall maintain an office, which will be open during normal business hours and staffed with qualified personnel.
10. An annual operating budget, including all actual and anticipated revenue and expenses must be submitted to the Alabama Medicaid Agency prior to the signing of the initial contract. The budget must comply with Governmental Accepted Accounting Principles (GAAP) guidelines. The DSP Agency must maintain an annual operating budget, which shall be made available to the Alabama Medicaid Agency upon request.
11. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Alabama Medicaid Agency. The DSP Agency home office must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP must provide private duty nursing services even when the office is closed. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will assure that the service is rendered.

H. Provider Experience

Providers of the private duty nursing service must meet all provider qualifications prior to rendering the private duty nursing service.

APPENDIX B-2B

Criteria for Private Duty Nursing Services under Technology Assisted Waiver for Adults

Private Duty Nursing – The services must be prescribed by a physician, be skilled nursing services which comply with the Alabama Board of Nursing Nurse Practice Act and the practice of professional nursing services or practical nursing as described under the Alabama Board of Nursing Administrative Code, 610-X-6 and must be rendered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of a Registered nurse employed by a Medicaid private duty nursing provider. Services requested must be medically necessary defined as meeting all Approval Criteria for coverage. A review for medical necessity must be conducted prior to authorization for service provision, must meet Alabama Medicaid prior authorization approval criteria for coverage and are to be provided in the recipient's home. However, recipients eligible for private duty nursing services in the home may qualify for private duty nursing hours when the recipient's normal life activities take them outside the home. To qualify for private duty nursing services, the recipient must have a life threatening condition. A qualified caregiver must be available for training as required for qualification for private duty nursing services. The qualified caregiver will be required to sign the Private Duty Nursing Acceptance Form (Appendix D-4C) and PDN Rights and Responsibilities Form (Appendix D-4B). Whenever required Approval Criteria are no longer met, the recipient must be transitioned to other nursing services or services will be discontinued if no longer medically necessary. By signing the ***Private Duty Nursing Acceptance Form***, the recipient, qualified caregiver, and the recipient's support network acknowledges that private duty nursing care number of hours may be reduced to the extent appropriate to the condition with the expectation of transition to other appropriate nursing or other services.

Requirements for participation are indicated below:

The goal of private duty nursing services is to make the individual as independent as possible. Private duty nursing is considered supportive to the care provided to a recipient by the recipient's family, and/or qualified caregiver. There must be a clear agreement with the individual and caregiving network to work towards developing methods to ensure that care and services are provided in the most efficient manner practicable, to include the expectation about regression of nursing hours when appropriate with eventual goal to transition to other nursing services or to discontinue all services as appropriate when eligibility or private duty nursing criteria are no longer met.

1. Major commitment on the part of the recipient's family and community is mandatory to meet the recipient's needs. The recipient must depend upon a support network to provide a support mechanism at home. Specific components include:

(i) At least one qualified caregiver must be identified, trained and fully able to care for the recipient in the home. In the event the caregiver for an enrolled individual is no longer

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available, the State will provide reasonable assistance to the individual to find an appropriate caregiver or to transition to alternate covered services for which he/she may be eligible.

(ii) An appropriate home environment must exist that insures the health and safety of the recipient (e.g., physical environment, safety, and geographic location for the recipient's medical safety);

(iii) A physician must be involved in the development of the recipient care plan prior to admission to the private duty nursing program, be knowledgeable about the plan, and agree to provide documented primary medical care;

(iv) Essential equipment must either be portable or available at each site that the recipient attends; and

(v) Reasonable plans for emergencies (e.g., power and equipment backup for those with life-support devices), an Emergency Medical Plan and transportation must be established.

2. Approval Criteria for private duty nursing services.

(i) Individuals applying for private duty nursing services through the Technology Assisted Waiver for Adults must meet all of the following criteria for coverage:

(I) Must have received services under the Alabama Medicaid Agency Private Duty Nursing Services program, Alabama Medicaid Agency Administrative Code, Chapter 11 and;

(II) Must meet the Nursing Home level of care requirements; and

(III) Must in addition meet one or more of the following:

A. Must depend on mechanical ventilators at least 8 hours per day;

B. Must require continued administration of at least 90 days duration for intravenous administration of nutritional substances or other drugs beyond nursing hours available through home health; or

C. Must require CPAP/BiPAP at least 12 hours each day.

3. A care plan must be developed and submitted with each request for service documenting the recipient's multidisciplinary needs. Careful review of the recipient's status and needs should be made by each professional participating in the recipient's care. Each discipline must formulate goals and objectives for the recipient and develop daily program components to meet these goals in the home. This plan must include the following:

(i) Designation of the direct service provider and targeted case manager;

(ii) Involvement of a physician providing primary care services to the recipient with specific physician orders for medications, treatments, medical follow-up, and medical tests as appropriate;

(iii) Caregiver/family and client access to a telephone;

(iv) A plan for monitoring and adjusting the care plan;

(v) A defined Emergency Medical Plan for medical emergencies;

(vi) A documented plan for reduction of private duty hours to the extent medically appropriate; and

(vii) Criteria **and** procedures for transition from private duty nursing care, when appropriate.

4. Upon approval, private duty nursing services may be authorized for a maximum of 84 hours per week except as provided in subsection five (5). Nursing services must be required beyond the scope of home health with a minimum of 4 hours per day for at least 3 days a week.
5. The Agency may authorize additional hours for a maximum of ninety- (90) days if any of the following apply:
 - (i) Immediately following hospital discharge when the qualified caregiver is being trained in care and procedures;
 - (ii) There is an acute episode that would otherwise require hospitalization, and the treating physician determines that non-institutionalized care is still safe for the client; or
 - (iii) The approved caregiver is ill or temporarily unable to provide care. An alternative qualified caregiver must be identified and trained; or
 - (iv) The Alabama Medicaid Agency determines it is medically necessary upon review of submitted medical documentation. Approval of hours in excess of 12 hours per day may be granted subject to review every ninety- (90) days.
6. At each certification, the care plan will be denied, approved, or additional information will be requested. The recipient must be transitioned to the most appropriate level of care when the recipient no longer meets the private duty nursing criteria for approval. The most appropriate care may be home care services, Home and Community Based Waiver Program services, or nursing home placement.
7. Private duty nursing service providers are required to submit documentation for certification and recertification as outlined in the Scope of Service definition in the approved waiver document, Technology Assisted Waiver for Adults.
8. Non-Covered private duty nursing services include the following:
 - (i) When it is determined that the recipient does not meet the medical criteria and/or does not require at least 4 consecutive hours of continuous skilled nursing care at least 3 or more days per week;
 - (ii) Behavioral or eating disorders, observational care, or monitoring medical conditions which do not require medically necessary intervention by skilled nursing personnel;
 - (iii) Services not prescribed to treat or ameliorate a condition. The conditions identified must meet the required medical criteria;
 - (iv) Custodial, sitter, and respite services;
 - (v) Services after the recipient is admitted to a hospital or a nursing facility;
 - (vi) Services after the recipient is no longer eligible for Medicaid;
 - (vii) Services solely for the convenience of the recipient, the recipient's family/caregiver or a provider; or
 - (viii) Services adequately, safely and effectively provided by home health.
9. Failure by the provider to comply with agency rules and program policies contained in the Scope of Service definition in the approved waiver document, Technology Assisted Waiver for Adults may result in termination of the provider contract.

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APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

_____ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

 X A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid Agency.

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SECTION 1915(c) WAIVER FORMAT

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan.
(Check all that apply.)

1. X Low income families with children as described in section 1931 of the Social Security Act.
2. X SSI recipients (SSI Criteria States and 1634 States).
3. Aged, blind or disabled in 209(b) States who are eligible under ' 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4. Optional State supplement recipients
5. Optional categorically needy aged and disabled who have income at (Check one):
 - a. 100% of the Federal poverty level (FPL)
 - b. % Percent of FPL which is lower than 100%.
6. X The special home and community-based waiver group under 42 CFR 435.217
(Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

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Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

_____ A. Yes X B. No

Check one:

a. _____ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. X Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) X A special income level equal to:

X 300% of the SSI Federal benefit (FBR)

_____ % of FBR, which is lower than 300% (42 CFR 435.236)

\$ _____ which is lower than 300%

(2) _____ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) _____ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324.)

(4) _____ Medically needy without spenddown in 209(b) States.
(42 CFR 435.330)

(5) _____ Aged and disabled who have income at:

a. _____ 100% of the FPL

b. _____ % _____ which is lower than 100%.

(6) _____ Other (Include statutory reference only to reflect additional groups included under the State plan.)

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7. _____ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)
8. _____ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

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Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under '435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community ('435.217). For individuals whose eligibility is not determined under the spousal rules ('1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR '435.726 and '435.735 just as it does for other individuals found eligible under '435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under '1924.

REGULAR POST-ELIGIBILITY RULES--'435.726 and '435.735

- o The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- o If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.
- o If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

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- o If other family members are living with the individual, an additional amount is protected or their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--'1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of '1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The '1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in '1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the '1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY**REGULAR POST ELIGIBILITY**

1. X **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

A. ' 435.726 --States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. X The following standard included under the State plan (check one):

(1) SSI

(2) Medically needy

(3) X The special income level for the institutionalized

(4) The following percent of the Federal poverty level): %

(5) Other (specify):

B. The following dollar amount:
\$ *

* If this amount changes, this item will be revised.

C. The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

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A.____SSI standard

B.____Optional State supplement standard

C.____Medically needy income standard

D.____The following dollar amount:
\$_____*

* If this amount changes, this item will be revised.

E.____The following percentage of the following standard that is not greater than the standards above: _____% of _____standard.

F.____The amount is determined using the following formula:

G.____ Not applicable (N/A)

3. Family (check one):

A.____ AFDC need standard

B.____Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the States approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.____The following dollar amount:
\$_____*

*If this amount changes, this item will be revised.

D.____The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

E.____The amount is determined using the following formula:

F.____ Other

G.____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

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POST-ELIGIBILITY**REGULAR POST ELIGIBILITY**

1.(b)___**209(b) State, a State that is using more restrictive eligibility requirements than SSI.** The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. Individual: (check one):

A. ___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income
level for the institutionalized

(4)___ The following percentage of
the Federal poverty level: ___%

(5)___ Other (specify):

B. ___ The following dollar amount:

\$ ___ *

* If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under ' 435.217, **enter NA in items 2. and 3.** following.

2. ___ spouse only (check one):

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A. ____ The following standard under 42 CFR 435.121:

B. ____ The medically needy income
standard ____;

C. ____ The following dollar amount:
\$ ____ *

* If this amount changes, this item will be
revised.

D. ____ The following percentage of the following standard that is
not greater than the standards above: ____ % of

E. ____ The following formula is used to determine the amount:

F. ____ Not applicable (N/A)

3. family (check one):

A. ____ AFDC need standard

B. ____ Medically needy income
standard

The amount specified below cannot exceed the higher of
the need standard for a family of the same size used to
determine eligibility under the State's approved AFDC plan
or the medically income standard established under
435.811 for a family of the same size.

C. ____ The following dollar amount:

\$ ____ *

* If this amount changes, this item will be
revised.

D. ____ The following percentage of the following standard that is
not greater than the standards above: ____ % of
standard.

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E.____ The following formula is used to determine the amount:

F.____ Other

G.____ Not applicable (N/A)

- b. Medical and remedial care expenses specified in 42 CFR 435.735.

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POST ELIGIBILITY**SPOUSAL POST ELIGIBILITY**

2._____The State uses the post-eligibility rules of '1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under ' 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a)____ SSI Standard

(b)____Medically Needy Standard

(c)____The special income level for the institutionalized

(d)____The following percent of the Federal poverty level:
____%

(e)____The following dollar amount
\$ ____**

**If this amount changes, this item will be revised.

(f) The following formula is used to determine the needs allowance:

(g)____Other (specify):

If this amount is different from the amount used for the individuals maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individuals maintenance needs in the community.

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APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS**APPENDIX D-1****a. EVALUATION OF LEVEL OF CARE**

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

_____ Discharge planning team

 X Physician (M.D. or D.O.)

 X Registered Nurse, licensed in the State

 X Licensed Social Worker

_____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

 X Other (Specify): Targeted Case Manager (RN or Licensed Social Worker)

The Alabama Medicaid Agency Nurse Reviewer will review 100% of waiver applications submitted to include the level of care determination of each waiver client.

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APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

_____ Every 3 months

 X Every 6 months

_____ Every 12 months

 X Other (Specify):

More frequently if necessary based on changes in the client's condition. Monthly face-to-face case management visits are required to monitor the client's condition and evaluate the continued appropriateness of the service plan.

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

 X The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

_____ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

_____ Physician (M.D. or D.O.)

_____ Registered Nurse, licensed in the State

_____ Licensed Social Worker

_____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_____ Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

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X "Tickler" file

 Edits in computer system

 X Component part of case management

 Other (Specify):

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APPENDIX D-2A**QUALIFICATIONS AND RESPONSIBILITIES OF INDIVIDUALS PERFORMING INITIAL EVALUATION**

The Alabama Medicaid Agency develops the level of care criteria used to determine the individual's needs for Private Duty Nursing (PDN) Waiver services. The Medicaid Nurse Reviewer will be trained by staff from the Alabama Medicaid Agency in the use of the level of care criteria.

The case manager performing the initial level of care evaluation must meet the following educational requirements:

- Bachelor of Arts degree or a Bachelor of Science degree from an accredited college or university, preferably in a human services related field, or;
- Bachelor of Arts degree or a Bachelor of Science degree from an accredited School of Social Work, or;
- Bachelor of Science Degree in Nursing (BSN) from an accredited School of Nursing, licensed as a Registered Professional Nurse (RN) by the State of Alabama Board of Nursing in accordance with *Code of Ala., 1975, Section 34-21-21* or;
- Licensed as a Registered Professional Nurse (RN) by the State of Alabama Board of Nursing in accordance with *Code of Ala., 1975, Section 34-21-21*.

The Nurse Reviewer conducting 100% review of waiver client applications to ensure medical appropriateness and make the level of care determination must meet the following certification requirements:

- Licensed as a Registered Professional Nurse (RN) by the State of Alabama Board of Nursing in accordance with *Code of Ala., 1975, Section 34-21-21*.

The Alabama Medicaid Agency employs Nurse Reviewers who are responsible for conducting the initial level of care evaluations for individuals applying for admission and readmission to the PDN Waiver.

The case manager will perform the initial assessment and complete the level of care evaluation. The completed assessment will be forwarded to the individual's attending physician for the completion of the medical certification. The attending physician will review and sign the medical certification on the assessment, indicating that the individual requires the institutional level of care.

The assessment, including the physician's certification, is then forwarded to the AMA for review by a registered nurse who will conduct a 100% review of applications to ensure the medical appropriateness and make the level of care determination. If the AMA determines that the documentation does not support the individual's need for the level of care as determined by the case manager and the attending physician, the documentation will then be forwarded to the Alabama Medicaid Agency's staff physician review. The Alabama Medicaid Agency's staff physician will make the final decision to approve or deny waiver admission based upon the documentation provided. If a denial is issued, the recipient will receive a notice informing them of their right to an informal conference and/or a fair hearing.

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APPENDIX D-2B

Alabama Medicaid Agency

Long Term Care Division

Instructions for Completion of State of Alabama Home and Community Based Services (HCBS) Program Assessment Form

HCBS Page 1. Instructions

1. Indicate the type of application that is being submitted.
2. Indicate the date on which the form is being completed.
3. In the space provided, only supply information if a re-determination is being completed. Enter the ending date that appears on the most current LTC 2 notification. For example, if the dates given are January 5, 2002 through January 31, 2003, the date that should be entered is January 31, 2003.
4. Enter the current case manager's name.
5. Enter the county/area agency/and, or regional office name. For example, SARCOA (South Alabama Regional Council on Aging).
6. Enter agency phone number. This field should reflect the current case manager's phone number.
7. Enter the Case Number. This field may be left blank.
8. Enter the Medicaid number exactly as it appears on the Medicaid card. Financial eligibility should be verified and if the application is for institutional deeming or for 300% of SSI, then the financial application should be submitted to the Alabama Medicaid District Office for processing.
9. Enter the prior control number that has been assigned by the Operating Agency (OA). This number should always be a nine-digit number.
10. Enter the client's name exactly as it appears on the Medicaid card.
11. Enter the resident address of the client or the emergency address. This should never be a Post Office Box number.

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12. Enter the name of the city in which the client resides.
13. Enter the zip code of the address recorded in #12.
14. When providing directions begin with a central point of reference, such as the office location. Be specific and include landmarks and distances. For example, go north on 23rd Street from the Area Commission on Aging Office for 2 blocks. You will pass First Baptist Church on your right. Turn onto 3rd Avenue immediately past the church. Go to the 4th house on the left. House is tan with vinyl siding.
15. Enter the client's telephone number if applicable. In the event there is no phone, obtain a phone number of someone whom you may relay messages.
16. Enter the client's date of birth to include month, day and year.
17. Check the applicable box related to marital status.
18. Check the applicable box of the client's race.
19. Check the applicable box of the client's sex.
20. Check the applicable box of whether the client lives alone.
21. Enter the name of the client's primary care physician.
22. Enter the physician's address.
23. Enter the city for the physician's address.
24. Enter the state for the physician's address.
25. Enter the zip code for the physician's address.
26. Enter the phone number for the physician.
27. Enter the name of a person to contact in case of an emergency.
28. Enter the address of the emergency contact.
29. Enter the city of residence of the emergency contact.
30. Enter the phone number of the emergency contact.
31. Screen and indicate whether the person has a third party payor source.

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32. Screen for the indicator of Medicare for the client. If the client has Medicare, then the case manager will screen for both Part A and Part B. Note: Part A is associated with hospital coverage and Part B is associated with outpatient, DME, physician office visits, etc.
33. Indicate the present history of the client's home situation by checking the appropriate box. Has the client been maintained in the home with care, without care? Did the client come from a hospital or nursing home?
34. This section should be completed based upon the findings of the case manager of the home environment.
35. Check the appropriate box of the referral source of the client. If "other" is indicated, write in the referral source. The referral source could be a home health nurse, DHR worker, etc.
36. Indicate the current living situation of the client.
37. Record the name of the primary caregiver and their relationship to the client. Check the box that is applicable.
38. List any other names of members of the client's household and their relationships to the client.

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HCBS Page 2. Instructions

1. Enter the client's name exactly as it appears on the Medicaid card.
2. Enter the client's Medicaid number exactly as it appears on the Medicaid card.
3. An assessment of the recipient's activities of daily living should be done by the case manager. Check the boxes that apply to the recipient and include the name of the person and/or agency that is meeting these needs. Include the phone number in the appropriate column for the person providing these services.
4. The assessment should include a review of any medical or assistive devices that may be present and used or needed. Check the column that is applicable.
5. The assessment should include a history related to elimination problems. If yes is checked, the boxes that apply should also be checked. If no is checked, there is no need to make any other checks.
6. The case manager should review names of all medications. All non-prescription drugs taken by the client should be entered in this section.
7. A history related to the client's mental status should be obtained. Select any boxes that are specific to the client by placing a check in the box.
8. A history of any sensory impairments should be obtained during the screening process by the case manager. The applicable box for the client should then be checked.
9. Indicate the appropriate income category of the client. If the client is in the income category for 300% of SSI or institutional deeming, the application should be forwarded to the Alabama Medicaid Agency's District Office for processing.
10. Indicate all agencies that provided services in the home or the community within the past 3 months.
11. The comment section should include a narrative summary by the case manager that helps describe the needs of the client for home and community based services.

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HCBS Page 3. Instructions

1. Enter the agency name, address and phone number for mailing purposes or any questions that might arise by the physician when this form is routed to them for review and signature.
2. Enter the name of the recipient just as it appears on the Medicaid card.
3. Complete this section by checking the appropriate box if the client has a diagnosis of MR, MI, or DD.
4. This space authorizes the release of information for determination of eligibility for services. This space should be signed and dated by the client or their legal representative. If the client is unable to sign and there is no legal representative available, then an "X" marked by the patient is acceptable, but must be witnessed by an additional person.
5. Enter the client's 13-digit Medicaid number.
6. Enter the client's date of birth.
7. Enter the date that the client signature is obtained.
8. The case manager should check the appropriate box if there is a history of a psychological or psychiatric problem and attach a psych summary.
9. This space indicates that the recipient has been given a choice between nursing home care and home and community based services. Once the client signs, this indicates that they have chosen home and community services. The same information as explained in # 4 above related to signatures is also applicable here.
10. Indicate all current diagnoses by checking those that are applicable.
11. The required services section contains the current Medicaid medical criteria for admission into programs. All new and re-admissions must meet (2) criteria. Re-determinations must meet one criterion. Supporting documentation of these criteria must be present in the application.
12. Any additional diagnoses not previously indicated should be documented in this column.
13. Check the appropriate box. If yes is checked in this section, then the type of special or therapeutic diet the client is receiving should be noted under the

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section labeled "Describe". Example: Glucerna per g-tube bolus feedings 4 times per day, 1800 Calorie ADA diet, etc.

14. The recipient should be screened for allergies. Check the appropriate box. If a history of allergies is present then the type of allergy, or name of medication that produces allergy symptoms should be listed in the column labeled describe.
15. The patient should be screened for any history of communicable diseases and the appropriate box checked.
16. The physician certification must indicate that the client requires home and community based services. The statement on the form now states "I certify that without Home and Community Based Services that this patient would be at risk for nursing facility care."
17. The physician must sign this statement. A stamp is not acceptable. A certified registered nurse practitioner's (CRNP's) signature is not acceptable.
18. The physician's signature must be dated.
19. The address of the physician signing this form should be recorded.
20. The city of the physician's address should be recorded.
21. Prescription medications to include frequency should be listed in this column.
22. The telephone number of the physician signing this form should be recorded.

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APPENDIX D-3**a. MAINTENANCE OF RECORDS**

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

☒ By the Medicaid agency in its central office

☐ By the Medicaid agency in district/local offices

☒ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

☒ By the case managers

☐ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

☒ By service providers

☐ Other (Specify):

Client records will be made readily available for review by the Alabama Medicaid Agency upon request.

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION / ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

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X The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

_____ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

The level of care (LOC) form used by the State, as incorporated in this waiver proposal, is the form that is utilized for all other approved 1915(c) home and community based service (HCBS) waivers. This form differs from the form used for nursing facility placement, in that it requires a complete assessment of the client's home environment. However, the medical LOC criteria used to determine admission to the Technology Assisted Waiver for Adults is the same medical criteria used to determine admission to nursing facilities.

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APPENDIX D-4**a. FREEDOM OF CHOICE AND FAIR HEARING**

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
 - a. informed of any feasible alternatives under the waiver; and
 - b. given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.
3. The following are attached to this Appendix:
 - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
 - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
 - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
 - d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

The Certificate of Choice Form, attached as D-4A, the Rights and Responsibilities for Technology Assisted Waiver Services for Adults Form, attached as D-4B, and the Private Duty Nursing Acceptance Form, attached as D-4C, is maintained in the client's file located within the Alabama Medicaid Agency's service coordination agency providing PDN waiver case management services. In addition, copies of the form will be maintained with the PDN provider in the client record. Freedom of choice documentation will be made readily available for review by the Alabama Medicaid Agency upon request.

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APPENDIX D-4A

CERTIFICATE OF CHOICE**Title XIX Home and Community Based Service Waiver for
the Private Duty Nursing (PDN) Waiver for Adults**

*Under the provisions of Alabama's PDN Waiver, in accordance with the Social Security Act of 1965, as amended, applicants for waiver services or a designated responsible party with authority to act on the applicant's behalf will, when the applicant is found eligible for waiver services, be offered the alternative of home and community based services or institutional services.

Program: _____

Client's Name: _____

Client's Medicaid Number: _____

I have been given a choice between Community Services and nursing home care and I have chosen Community Services.

Signed: _____
(Recipient)

Witness: _____

Date: _____

Witness: _____

Signed: _____
(Patient Representative)

(Relationship)

Date: _____

DATE: _____

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APPENDIX D-4B

**ALABAMA MEDICAID AGENCY
TECHNOLOGY ASSISTED (TA) WAIVER FOR ADULTS
PRIVATE DUTY NURSING –RIGHTS AND DUTIES**

If you qualify for Private Duty Nursing Services under Medicaid's Technology Assisted Waiver for Adults . . .

When you signed up for Medicaid, you agreed to be a part of Medicaid and to follow Medicaid's rules. This also means that you have the following rights and duties when you qualify for Private Duty Nursing Services under Medicaid's TA Waiver for Adults:

If you are the person receiving care . . .

1. You have the right to change the company that provides nursing care or equipment for you. Your case manager can give you a list of companies you may choose from.
2. You have the right to stop your care at any time. To do this, you need to tell the case manager, the nurse or person providing nursing care of your wishes.
3. You have the right to be treated with respect by all people who care for you or who bring equipment or supplies for you. If this is not the case, tell your case manager.
4. You have the right to ask that Medicaid reconsider any decision to deny services. To do this, you must write Medicaid.
5. You have the right to ask for a hearing if you do not agree with the decision made by Medicaid about your care. To do this, you must write to Medicaid's Legal Division at: Alabama Medicaid Agency, 501 Dexter Avenue, PO Box 5624, Montgomery, AL 36103-5624.
6. You have the right to call or write Medicaid if you have a problem with your care that you are not able to solve on your own. For help, write to Medicaid's Long-Term Care Program Management Unit at 501 Dexter Avenue, PO Box 5624, Montgomery, AL 36103-5624, or call (334) 242-5658.

If you are the qualified caregiver . . .

1. You have the duty to help plan and carry out the care that is provided to the patient, with the help of skilled nurses.
2. You have the duty to work with the nurses to learn how to care for the patient on your own.
3. You have the duty to provide care for the patient when no nurse is present.
4. You have the duty to provide care or set up care when a nurse cannot come because of a good reason, such as illness or bad weather.
5. You have the duty to tell the nursing agency ahead of time when a nurse is not needed for a visit that has already been set up.
6. You have the duty to take good care of all medical equipment provided for the patient. This means that you do not let others play with or damage the equipment.
7. You have the duty to tell the case manager or the supply company when supplies are sent that are not needed. This also applies when too much of an item is brought to the home.
8. You have the duty to tell the case manager or nursing agency of any change in the patient's condition, good or bad. You must tell the case manager if the patient must go to the hospital.
9. You have the duty to first work with your case manager, the nurses and/or the company providing care to solve any problems before contacting Medicaid.

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The nursing agency has the duty to:

1. Provide skilled nursing services based on the plan of care that has been approved for the patient.
2. Provide nurses who are on time, clean, professional and who pay attention to the health care needs of the patient.
3. Send a RN supervisor at least every 60 days to the home for a visit to check on the patient's care.
4. Provide care for the patient's health needs only. For example, nurses are not to perform duties that would be done by sitters or drivers.
5. Set up a make-up visit within one (1) day of any shift that has been missed. The nursing agency's supervisor has the duty to make sure the health and safety needs of the patient are met.
6. The nurses and others who give direct patient care have the duty to show and teach the patient's caregiver how to care for the patient on their own. This means that the nurses and others will provide help and feedback to the caregiver so they may learn all that is needed to care for that patient.

The direct service provider(s) has the duty to:

1. Periodically check to make sure that the patient continues to qualify to be a part of the TA Waiver for Adults. This is to be done by the case manager and Medicaid.
2. Work with the patient, caregiver, case manager and physician to develop a plan of care that matches the patient's medical needs and to update the plan whenever the patient's condition changes.
3. Work with the patient and caregiver to plan and prepare for eventual discharge from private duty nursing when medically appropriate.

Signed:

Client/Patient (if applicable)_____ Date_____

Qualified Caregiver_____ Date_____

Case Manager_____ Date_____

Direct Service Provider _____ Date_____

Physician _____ Date_____

DATE : _____

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APPENDIX D-4C

**TECHNOLOGY ASSISTED (TA) WAIVER FOR ADULTS
PRIVATE DUTY NURSING – AGREEMENT FOR CARE**

Private duty nursing under Medicaid' TA Waiver for Adults is set up to help patients whose health needs go beyond the care that can be given through home health. This type of care is set up to help family members or other caregivers get ready to care for the patient on their own. Private duty nursing is not intended to replace care given by family members or others in the home.

Medicaid is a voluntary program. This means that when the patient signed up for Medicaid, the patient or family member agreed to be a part of Medicaid and follow Medicaid's rules.

By signing this form you, the qualified caregiver, agree:

1. That the goal of private duty nursing care is to help you, family members or other caregivers get ready to care for the patient on your own or to move him or her to another type of care to match the patient's medical needs.
2. That the number of private duty nursing hours will be reduced to match the patient's medical needs over time.
3. That private duty nursing does not replace the care given by family or other caregivers in the home.
4. To work with the nursing staff to learn how to care for the patient on your own.
5. That the following services are NOT COVERED by Medicaid private duty nursing under the TA Waiver for Adults:
 - A. Services that can be provided in a safe, complete and effective manner by home health.
 - B. Services for the convenience of the patient, family or caregiver, such as the services of a sitter or driver.
 - C. Custodial, sitter or respite services of any kind.
 - D. Services when the patient is in the hospital or a nursing home
 - E. Services at any time the patient does not qualify for Medicaid or for private duty nursing
 - F. Services for behavioral or eating disorders, for observation or for monitoring medical conditions which do not require skilled nursing care.

I have been given a copy of the rules for private duty nursing and I have had the chance to ask questions about anything on this form and about private duty nursing under the Medicaid waiver. By signing this form, I am saying that I understand all of the rules for private duty nursing under the TA Waiver for Adults and agree to follow them in order for the patient to get this care.

Signed:

Patient/Client (if applicable) _____ Date _____

Qualified Caregiver _____ Date _____

Case Manager _____ Date _____

Private Duty Nursing Agency _____ Date _____

Other Direct Service Provider (if applicable) _____ Date _____

Physician _____ Date _____

DATE : _____

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APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

 X Registered nurse, licensed to practice in the State

 Licensed practical or vocational nurse, acting within the scope of practice under State law

 X Physician (M.D. or D.O.) licensed to practice in the State

 Social Worker (qualifications attached to this Appendix)

 X Case Manager

 Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

 X At the Medicaid agency central office

 At the Medicaid agency county/regional offices

 X By case managers

 X By the agency specified in Appendix A

 By consumers

 X Other (specify):

Private Duty Nursing Service Provider
Personal Care/Attendant Service Provider

The Alabama Medicaid Agency Nurse Reviewer will review 100% of waiver applications submitted to include Plans of Care of each waiver client.

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3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

_____ Every 3 months

 X Every 6 months

_____ Every 12 months

 X Other (specify):

More frequently if necessary based on changes in the client's condition. Monthly face-to-face case management visits are required to monitor the client's condition and evaluate the continued appropriateness of the service plan.

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APPENDIX E-1A

Alabama Medicaid Agency**Long Term Care Division****Instructions for Completion of State of Alabama
Home and Community Based Services (HCBS) Program
Assessment Form****HCBS Page 4. Instructions – Plan of Care**

1. Print or type the client's name. The space below is to be utilized for the client's signature indicating that he/she is in agreement with the plan of care.
2. Enter the client's 13-digit Medicaid number.
3. Enter the case manager's name. The case manager must sign on the line below his/her printed name indicating that the plan of care was reviewed with the client.
4. Enter the current date. The space below should contain the date that the client reviewed and signed the plan of care.
5. Indicate the objective you wish to obtain of each waiver service listed.
6. List the exact service to be provided.
7. Enter the name of the provider of each service.
8. Enter the frequency of each service listed. The frequency must be specific. For example, 2 hours, 2 times per week for Homemaker service.
9. Enter the date that the service will begin.
10. Enter the ending date only if the service is stopped or if the frequency changes. For example: The homemaker hours are 2 hours, 2 times per week, and the client is admitted to the hospital. The client is discharged from the hospital. The re-assessment completed by the case manager indicates a need to increase the service provision to 2 hours, 3 times per week. There would be an end date listed for the initial homemaker service and the new homemaker service hours would be listed on the care plan with the new start of care date.
11. Enter the objective of the non-waiver service(s).
12. Enter the name of the non-waiver service(s).

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13. Enter the name of the provider of non-waiver service(s).
14. Enter the frequency of the non-waiver service(s).
15. Enter the start date of the non-waiver service(s).
16. Enter the ending date of the non-waiver service(s).
17. Enter the date that the case manager completes the 60-day review.

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APPENDIX E-2**a. MEDICAID AGENCY APPROVAL**

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency: **See Attachment – Appendix E-2A**

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

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PLAN OF CARE DEVELOPMENT

The following is a description of the process by which the Plan of Care is developed.

- The Alabama Medicaid Agency develops the level of care criteria and the Plan of Care (POC) document.
- The Alabama Medicaid Agency provides case management training related to the assessment of the individual and the method of developing the Plan of Care based on specific individual's needs.
- The POC will include the types of service, the number of units of service, the frequency and duration of each service, and the provider of each service.
- The AMA will designate a registered nurse to review and approve both the Plan of Care and the level of care assessment prior to initiating service delivery. The AMA nurse will ensure that all federal and state requirements are met prior to initiating service delivery.
- The Alabama Medicaid Agency Nurse Reviewer will review 100% of applications submitted to include the POC.
- The Alabama Medicaid Agency Nurse Reviewer will conduct annual onsite reviews of 100% of direct service providers. The onsite review will include a review of the POC and client assessment to ensure compliance with the level of care and delivery of services included on the POC.

APPENDIX F - AUDIT TRAIL**a. DESCRIPTION OF PROCESS**

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.
3. Method of payments (check one):

 X Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

 Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

 Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

 Other (Describe in detail):

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b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:
 - a. When the individual was eligible for Medicaid waiver payment on the date of service;
 - b. When the service was included in the approved plan of care;
 - c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

_____ Yes

 X No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

 X All claims are processed through an approved MMIS.

_____ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

 X The Medicaid agency will make payments directly to providers of waiver services.

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X The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

_____ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

_____ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will **not** be required to do so. Direct payments will be made using the following method:

A detailed description of the billing process to be utilized for the proposed waiver is attached as Appendix F-1.

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

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APPENDIX F-1**DESCRIPTION OF THE BILLING PROCESS**

- (1) For dates of service beginning January 1, 2003 (FY-04) and after, payments made by Medicaid to providers will be on a fee-for-service basis. Each covered service is identified on a claim by a procedure code.
- (2) For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month; however no single claim can cover services performed in different months. For example, claims with dates of service of 1/15/03 to 2/15/03 would not be allowed. If the submitted claim covers dates of service where part, or all of which were covered in a previously paid claim, the claim will be rejected.
- (3) Payment will be based on the number of units of service reported on the claim for each procedure code.
- (4) Accounting for actual cost and units of services provided during a waiver year must be captured on HCFA Form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:
 - (a) A waiver year consists of twelve consecutive months starting with the approval date specified in the approved waiver document.
 - (b) An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public/governmental provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-case payments, such as depreciation, occur when transactions are recorded by the state agency.
 - (c) The services provided by a DSP agency is reported and paid by dates of service. Thus, all services provided during the twelve months of the waiver year will be attributed to that year.
- (5) Providers must retain records that fully disclose the extent and cost of services provided to the eligible recipients for a five (5) year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials.
- (6) There must be a clear differentiation between waiver services and non-waiver services. There must be a clear audit trail from the point a service is provided through billing and reimbursement. The Alabama Medicaid Agency and Centers for Medicare and Medicaid Services (CMS) must be able to review the Plan of Care to verify the exact service and number of units provided, the date the service was rendered, and the direct service provider for each recipient. There must be a detailed explanation of how waiver services are segregated from ineligible waiver costs.

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APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
 COMPOSITE OVERVIEW
 COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: **NF**

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	\$59,678	\$52,006	\$85,096	\$50,220
2	\$66,224	\$53,774	\$87,989	\$51,927
3	\$65,450	\$55,603	\$90,981	\$53,693
4				
5				

NOTE: These estimates do not include additional prior authorized hours which may be approved to ensure health and safety. These additional prior authorized hours will not cause this waiver to lose its cost neutrality.

DATE: _____

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FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR UNDUPLICATED INDIVIDUALS

1 30

2 35

3 40

4

5

EXPLANATION OF FACTOR C:

Check one:

 X The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

 The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit, which is less than factor C for that waiver year.

DATE: _____

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APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: NF

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

DATE: _____

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APPENDIX G-3
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

NA

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

NA

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APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

 X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

 The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

NA

DATE: _____

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APPENDIX G-5

FACTOR D'

LOC: **NF**

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services **WHILE THE INDIVIDUAL WAS ON THE WAIVER.**

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began **AFTER** the person's first day of waiver services and ended **BEFORE** the end of the waiver year **IF** the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred **BEFORE** the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

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APPENDIX G-5

FACTOR D' (cont.)

LOC: **NF**

Factor D' is computed as follows (check one):

 Based on HCFA Form 2082 (relevant pages attached). Based on HCFA Form 372 for years of waiver
, which serves a similar target population. Based on a statistically valid sample of plans of care for individuals with the disease or condition
specified in item 3 of this request. **X** Other (specify): The computation for Factor D' was obtained from paid claims data derived from a query, which included all Medicaid costs for recipients receiving private duty nursing services who lived in the community during fiscal years 2000-2002. Average costs per year were obtained from the data yielded and expanded benefits were deducted to determine a more accurate amount for acute care costs expected to be reimbursed for individuals 21 and over. An inflation factor of 3.4 percent was applied to each subsequent year of the initial waiver request.DATE:

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APPENDIX G-6

FACTOR G

LOC: NF

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

_____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

_____ Based on trends shown by HCFA Form 372 for years ____ of waiver #____, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

_____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

_____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

 X Other (specify): The computation for Factor G was obtained from paid claims data derived from a query, which included all Medicaid institutional costs for recipients residing in an out of state nursing facility during fiscal year 2002. An inflation factor of 3.4 percent was applied to each subsequent year of the initial waiver request.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

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APPENDIX G-7

FACTOR G'

LOC: **NF**

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

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APPENDIX G-7

FACTOR G'

LOC: **NF**

Factor G' is computed as follows (check one):

 Based on HCFA Form 2082 (relevant pages attached). Based on HCFA Form 372 for years of waiver
, which serves a similar target population. Based on a statistically valid sample of plans of care for individuals with the disease or condition
specified in item 3 of this request. **X** Other (specify): The computation for Factor G' was obtained from paid claims data derived from a query, which included Medicaid acute care costs (e.g. physician office visits, inpatient hospital care, outpatient hospital care, etc.) provided for recipients who resided in an out of state nursing facility during fiscal year 2002. An inflation factor of 3.4 percent was applied to each subsequent year of the initial waiver request.DATE:

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APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: NF

YEAR 1

FACTOR D:	<u>\$59,678</u>		FACTOR G:	<u>\$85,096</u>
FACTOR D':	<u>\$52,006</u>		FACTOR G':	<u>\$50,220</u>
TOTAL:	<u>\$111,684</u>	\leq	TOTAL:	<u>\$135,316</u>

YEAR 2

FACTOR D:	<u>\$66,224</u>		FACTOR G:	<u>\$87,989</u>
FACTOR D':	<u>\$53,774</u>		FACTOR G':	<u>\$51,927</u>
TOTAL:	<u>\$119,998</u>	\leq	TOTAL:	<u>\$139,916</u>

YEAR 3

FACTOR D:	<u>\$65,450</u>		FACTOR G:	<u>\$90,981</u>
FACTOR D':	<u>\$55,603</u>		FACTOR G':	<u>\$53,693</u>
TOTAL:	<u>\$121,053</u>	\leq	TOTAL:	<u>\$144,674</u>

DATE: _____

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DOCUMENTATION TO SUPPORT FACTORS G, G' AND D'

The base data for G and G' was obtained from a report generated by the Alabama Medicaid Agency for the period of October 1, 1999-September 30, 2000, to identify Medicaid recipients residing in an Alabama Medicaid enrolled nursing facility in Louisiana. The Alabama Medicaid recipients in this facility are technology dependent who were unable to secure placement within the State of Alabama. The base data for Factor D' was obtained from a report of Medicaid paid claims data generated by the Agency for a period of October 1, 1999 – September 30, 2002, to obtain the average costs per year, which would yield more accurate data for the population to be served by the proposed waiver.

The individuals identified were used for the purpose of calculating Medicaid institutional costs. Medicaid cost for the three (3) individuals identified totaled \$255,288 for an average cost of \$85,096 per recipient (Factor G). An inflation factor of 3.4% was applied to each subsequent year of the initial waiver request.

The Medicaid acute care cost for 70 individuals identified totaled \$9,061,713 after the inpatient cost of (\$2,605,272) was extracted. After this amount was removed, the total for the three (3) year period was \$129,453 which equals \$43,151 for each year represented.

The Medicaid Agency recalculated the inpatient cost extracting the expanded benefits given to individuals under age 21 from the total inpatient cost identified. The inpatient cost of \$8,855 was added to \$43,151 for a Factor D' total of \$52,006. An inflation factor of 3.4% was applied to each subsequent year of the initial waiver request.

The data for factor G' was based on five (5) individuals in the nursing facility in Louisiana. The cost for all other services totaled \$17,633. Since this cost only represented five (5) individuals, we feel a more accurate estimate is the acute care cost for the prior three years (3) for the individuals receiving private duty nursing services. In arriving at the new estimate, we extracted the cost for the expanded benefits for outpatient (\$1,189) and inpatient (\$4,197). The cost for outpatient claims was \$87,355 per client for a (3) year period which equals \$29,118 per client per year. The amount of \$8,855 was added to revised G', for a total amount of \$50,220. An inflation factor of 3.4% was applied to each subsequent year of the initial waiver request.

For Year two (2) and three (3), Factor D was calculated at 12 hours per day with an average length of stay of 245 days times 90% which assumes some reduction of Year two (2) and three (3).

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APPENDIX H**REQUIREMENTS FOR REPORTING COMPLAINTS & GREIVANCES RECEIVED BY THE ALABAMA MEDICAID AGENCY**

- Complaints filed by recipients may be reported directly to the Alabama Medicaid Agency (AMA). A tracking log will be used to document the incidents and the resolution and maintained at the AMA Long Term Care (LTC) Program Management Unit.
- If the complaint is related to a denial of waiver services:
 - a. Complaint will be submitted to the LTC Admissions/Records Unit.
 - b. The appropriate staff member will review the information received and make a decision within seven (7) working days. If a decision cannot be reached, additional information will be requested.
 - c. Resolution will be reached within seven (7) working days from receipt of the additional information with a response disseminated to all parties involved.
 - d. If the individual is not satisfied with the decision made by the AMA they have the right to request an informal conference within 30 days from the initial decision.
 - e. If the individual is not satisfied with the informal conference decision, they have 60 days from the date of the decision of the informal conference to request a fair hearing.
- If the complaint is related to delays with or denials of financial eligibility:
 - a. Complaint will be submitted to the Elderly and Disabled Certification Division's District Office.
 - b. The appropriate staff member will review the information received and make a decision within seven (7) working days. If a decision cannot be reached, additional information will be requested.
 - c. Resolution will be reached within seven (7) working days from receipt of the additional information with a response disseminated to all parties involved.
 - d. If the individual is not satisfied with the decision made by the AMA they have the right to request an informal conference within 30 days from the initial decision.
 - e. If the individual is not satisfied with the informal conference decision, they have 60 days from the date of the decision of the informal conference to request a fair hearing.
- If the complaint is related to providers or workers:
 - a. Complaint will be submitted to the LTC Quality Assurance.
 - b. The appropriate staff member will review the information received and make a decision within seven (7) working days. If a decision cannot be reached, additional information will be requested.
 - c. Resolution will be reached within seven (7) working days from receipt of the additional information with a response disseminated to all parties involved.
 - d. If the individual is not satisfied with the decision made by the AMA they have the right to request an informal conference within 30 days from the initial decision.
 - e. If the individual is not satisfied with the informal conference decision, they have 60 days from the date of the decision of the informal conference to request a fair hearing.

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